

BENEFIT DESCRIPTION OF DENTAL CARE COVERAGE

This Benefit Description of Dental Care Coverage (hereinafter referenced to as “Plan”) is issued on behalf of the State of Kansas by Delta Dental of Kansas, Inc., (hereinafter referenced to as “Delta Dental”) a nonprofit dental service corporation incorporated under the laws of Kansas.

This document is intended to be an easy-to-read outline of the principal features of your dental program. The dental benefits provided are fixed, and limited to those defined within this Benefit Description of Dental Care Coverage. Only the Least Expensive Alternative Treatment (LEAT) is covered under this program and then only if identified as a covered dental benefit in this Benefit Description of Dental Care Coverage. Certain restrictions may be applicable to your coverage. It is important to review the entire document.

The Dentist and the member, not Delta Dental or the Group, determine the course of treatment. Whether or not the Plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

If any state or federal legislation or regulation is in effect, enacted, or amended mandating a change in the dental benefits described in this booklet, appropriate modifications will be made in the benefits provided.

DEFINITIONS

For the purpose of this Benefit Description of Dental Care Coverage, the following definitions shall apply:

Accidental Injury means an unusual and external force applied to the teeth. Accidental injury does not include damage to the teeth as a result of biting, chewing, disease or infection.

Allowed Amount means the Maximum Plan Allowance for the Least Expensive Alternative Treatment needed to restore the tooth or dental arch to contour and function as determined by the Plan.

Annual Maximum means the maximum benefit payable by the Plan per Eligible Person per Benefit Period.

Benefit Date means the effective date of the coverage provided by the Group.

Benefit Description of Dental Care Coverage means a summary of the plan provisions provided by the Group.

Coinsurance means the percentage of the Allowed Amount for a covered service at which payment is made after any applicable Deductible amount has been satisfied.

Cosmetic Treatment when describing dentistry means those services provided by Dentists for the purpose of improving the oral appearance when form and function are otherwise satisfactory.

Deductible means the amount of the Allowed Amount for covered services to be paid by a member before benefits can be provided for covered services. The Deductible applies only to specific services outlined in this Benefit Description of Dental Care Coverage.

Delta Dental PPO Provider means a dental provider who has agreed to render services in accordance with specific terms and conditions of the Delta Dental PPO network established by Delta Dental.

Delta Dental Premier Provider means a dental provider who has agreed to render services in accordance with specific terms and conditions of the Delta Dental Premier Network established by Delta Dental.

Dentist means any duly licensed person entitled to practice dentistry at the time and in the place the dental services are performed.

Dependent is a lawful wife or husband or an unmarried child or step-child of a member's family who meets the eligibility requirements and who is properly enrolled for coverage by the member and on whose behalf premiums are paid by You or the Employer Group.

Full Mouth Restoration means crowns on ten (10) or more teeth.

Group means the State of Kansas.

Least Expensive Alternative Treatment (LEAT) means the limitation in this Benefit Description of Dental Care Coverage that will only allow benefits for the least expensive treatment.

Maximum Plan Allowance (MPA) means:

- a. Participating Dentists - In the case of Participating Dentists, the term "Maximum Plan Allowance" or "MPA" means the lesser of: 1) the fee submitted by the Participating Dentist for the dental procedure, 2) the fee that such Participating Dentist has filed with Delta Dental for the dental procedure, if any, or 3) the Delta Dental Participating Dentist Maximum Fee.

The "Delta Participating Dentist Maximum Fee" for a Covered Procedure means the fee established by Delta Dental. The Delta Dental Participating Dentist Maximum Fee is developed from a number of sources, including but not limited to contracts with dentists, input from dental consultants, consideration of the relative simplicity or complexity of the procedure, the billed charges for the same procedures by dentists in Kansas, and such other information as Delta Dental, in its sole discretion, deems appropriate.

- b. Non Participating Dentists - in the case of Non participating dentists, the MPA means the lesser of: the fee submitted by the Non Participating Dentist for the dental procedure, or the Delta Dental Non Participating Dentist Maximum Fee.

The "Delta Dental Non Participating Dentist Maximum Fee" for a Covered Procedure means the fee established by Delta Dental from time to time. The Delta Dental Non Participating Dentist Maximum Fee is developed from a number of sources, including but not limited to contracts with dentists, input from dental consultants, consideration of the relative simplicity or complexity of the procedure, the billed charges for the same procedures by dentists in the area of the State in which the services are performed, and such other information as Delta Dental, in its sole discretion, deems appropriate. Generally, the Delta Dental Non Participating Dentist Fee will reflect a reduction of the Delta Dental Non Participating Dentist Maximum Fee.

- c. Out of State Dentists - For services billed by dentists outside the State of Kansas, the Delta Dental Maximum Fee is based on information from the geographic area in which the dentist performs the procedure.

Member means an enrolled participant of the Group who meets and continues to meet all eligibility requirements for participating in the health benefit program established by the Group.

Non Participating Dentist means a dental provider who has not contracted with Delta Dental to participate in the Delta Dental PPO or Delta Dental Premier networks.

Plan means all of the covered dental benefits, exclusions and items listed within this Benefit Description of Dental Care Coverage that is administered by Delta Dental for the Group.

Plan Year means the time period that begins at 12:01 on January 1 and ends at midnight on December 31 yearly.

You or Your means the member.

**Schedule of Dental Plan Benefits
Plan Year 2007**

The percentage Coinsurance reflects what is paid of the Allowed Amount by the Plan:

PPO Panel	Premier Panel	Out-Of Network*	
100%	100%	100%	DIAGNOSTIC AND PREVENTIVE SERVICES: Oral examinations twice per Plan Year. Diagnostic x-rays: bitewings twice per plan year for dependents under age eighteen (18) and once per Plan Year for members age eighteen (18) and over. Full mouth x-rays once each five (5) years. Prophylaxis/cleanings (including periodontal maintenance) twice per plan year. Topical fluoride twice per plan year for dependent children under age nineteen (19). Space maintainers only for the premature loss of primary molars and only for dependent children under the age of fifteen (15). Sealants are covered for dependent children under age seventeen (17) and only when applied to permanent molars with no caries (decay) or restorations on the occlusal surface. Sealants are limited to one (1) per four (4) years.
100%	100%	100%	ANCILLARY: Provides for visits to the dentist for the emergency relief of pain.
80%	60%	60%	REGULAR RESTORATIVE DENTISTRY: Provides for amalgam (silver) restorations; composite (white) resin restorations; and stainless steel crowns for dependents under age twelve (12).

The following procedures are subject to a \$45 deductible per person, per Plan Year, not to exceed an annual family deductible of \$135.

80%	60%	60%	ORAL SURGERY: Provides for extractions and related oral surgical procedures performed by the dentist including pre- and post-operative care.
80%	60%	60%	ENDODONTICS: Includes procedures for root canal treatments and root canal fillings.
80%	60%	60%	PERIODONTICS: Includes procedures for the treatment of diseases of the gums and bone supporting the teeth.
50%	50%	50%	SPECIAL RESTORATIVE DENTISTRY: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for gold restorations and individual crowns.
50%	50%	50%	PROSTHODONTICS: Bridges, partial and complete dentures, including repairs and adjustments.
50%	50%	50%	TMJ: Treatment plan must be pre-authorized by Delta Dental. Treatment is limited to specific non-surgical procedures involving Temporomandibular Joint Dysfunction. Only the following procedures are covered: 07820—Closed reduction of dislocation 07880—Occlusal Orthotic Device 09951—Occlusal adjustment (limited) 09952—Occlusal adjustment (complete)

* Out of Network Services are subject to the Allowed Amount including the Maximum Plan Allowance for Non Participating Providers. For dental benefits and services provided by a Non Participating Provider, Delta Dental will determine the amount payable subject to the Allowed Amount and applicable Deductible and Coinsurance. Any amounts in excess of the Allowed Amount will be the member's responsibility.

ANNUAL MAXIMUM: The maximum paid by the Plan for the above treatments is \$1,700 per person per Plan Year.

ORTHODONTIC COVERAGE

Procedures for orthodontic appliances and treatment, including both interceptive and corrective, are covered at a 50% Coinsurance. If treatment is started prior to January 1, 2006, services are covered only when provided by a Delta Dental Plan participating Dentist. For orthodontic treatment started on or after January 1, 2006, members may use any licensed dentist for treatment. Orthodontic treatments are not subject to a Deductible and have a \$1,000 per person lifetime maximum. The lifetime maximum for orthodontic services does not apply to the Annual Maximum for other covered services.

Covered Dental Procedures:

- a. The Plan will cover the Least Expensive Alternative Treatment (LEAT). If either the dentist or the member selects a more expensive service or benefit option, the Plan will pay the applicable percentage of the fee for the Least Expensive Alternative Treatment toward the service provided. The remainder of the fee is not a covered benefit and is Your responsibility. The Dentist and the member, not Delta Dental or the Group, determine the course of treatment. Whether or not the Plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.
- b. Only the cost of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are covered dental benefits and then only if identified as a covered dental service in this Benefit Description of Dental Care Coverage.
- c. Some procedures and treatments may have specific age and frequency limitations. These limitations are identified in this Benefit Description of Dental Care Coverage.
- d. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the allocation of payment to each Dentist.
- e. A panoramic film in conjunction with a complete intraoral survey is not a separate benefit.
- f. Benefits for a seven (7) vertical bitewing series are not provided more frequently than once each two (2) years.
- g. Payment is made for a surface only once within a twenty-four (24) month period regardless of the number or combinations of restorations placed therein.
- h. Recementation of space maintainers are covered one (1) time per lifetime.
- i. Sealants are limited to once every four (4) years for dependents under age seventeen (17) and are covered on permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
- j. Amalgam (silver) restorations and composite (white) resin restorations are covered.
- k. Veneers are considered to be optional treatment. Benefit payment will be made for the restorative procedure appropriate to the degree of tooth breakdown.
- l. Available benefits for all inlays are on the basis of the Allowed Amount for an equal surface amalgam (silver restoration) with You being responsible for the difference in cost, if any.
- m. Provides for surgical placement of implants. Provides for implant attachments including implant abutments and implant crowns. All covered implants are made **elective** to the Maximum Plan Allowance for a three unit bridge and the remainder of the fee is Your responsibility. Implants are limited to members age sixteen (16) and over.
- n. Individual crowns are covered as follows:
 - (1) Individual crowns on the same tooth are a covered benefit only once in any five (5) year period. The time period is to be measured from the date the crown was supplied to You whether or not this coverage was effective at the time of service.
 - (2) Porcelain crowns, porcelain fused to metal; or resin processed to metal type crowns are not covered benefits for any person under sixteen (16) years of age.
 - (3) Recementation of a crown may be allowed for payment only once in a twelve (12) consecutive month period.
 - (4) Only two (2) repairs per crown will be allowed in a twelve (12) month time period.
 - (5) Stainless steel crowns are a covered benefit only for dependent children under the age of twelve (12) and are limited to once in a twenty-four (24) month period.

- (6) Coverage for core/crown build-ups, including pins is limited to permanent teeth having insufficient tooth structure.

o. Prosthetic appliances are subject to the following limitations:

- (1) You are eligible for only one (1) full upper and one (1) full lower denture in any five (5) year period. The time period is to be measured from the date the denture was last supplied to the member whether or not the Contract was then effective.
- (2) You are eligible for a partial denture, fixed bridge, or removable bridge once in any five (5) year period. The time period is to be measured from the date the denture or bridge was last supplied to You whether or not this coverage was effective at the time of service.
- (3) Denture relines and rebase (jumps) is a covered benefit only once in any thirty-six (36) month period.
- (4) Denture adjustments are a covered benefit only two (2) times in any twelve (12) month period.
- (5) No replacement will be made of any existing denture that in the opinion of Delta Dental is satisfactory or can be made satisfactory.
- (6) Crowns when used for abutment purposes are covered at the same Coinsurance as provided for bridges and complete and partial dentures.
- (7) Recementation of a bridge may be allowed for payment only once in a twelve (12) consecutive month period.
- (8) If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial towards the procedure submitted. If a fixed bridge, implant or other more expensive procedure is selected, the remainder of the fee is Your responsibility.
- (9) Only two (2) repairs per prosthesis, such as bridges, partials, or dentures, will be allowed in a twelve (12) month period.
- (10) Benefits for tissue conditioning are limited to no more than two (2) per arch per thirty-six (36) month period.

p. Payment for root canal therapy is limited to only once in any twenty-four (24) month period.

q. Payment is limited to only once in any twenty-four (24) month period for all periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis which is payable as a prophylaxis, subject to the same limitations and is limited to one (1) per lifetime; periodontal maintenance which is covered twice per plan year; and crown lengthening which carries no limitation.

r. Coverage for Temporomandibular Joint Dysfunction (TMJ) **MUST BE PRIOR AUTHORIZED** and is limited to:

Those intra-oral services which would normally be provided by a licensed dentist in the relief of oral symptoms associated with malfunctions of the TMJ are limited to the following:

- 07820—Closed reduction of dislocation
- 07880—Occlusal Orthotic Device
- 09951—Occlusal adjustment (limited)
- 09952—Occlusal adjustment (complete)

Exclusions:

- (1) Benefits for fixed appliances and restorations are excluded. Diagnostic procedures not otherwise specified as covered under this contract are excluded.
- (2) Repair and replacement of any appliances furnished in whole or in part under TMJ coverage is excluded.
- (3) Surgical treatment of TMJ and ancillary care, such as anesthesia and hospital stays are excluded.

All services for TMJ will be limited to the annual maximum amount stated in the Schedule of Dental Plan Benefits. No further benefits will be provided until five (5) years have passed from the last service in the prior course of treatment. If benefits from the initial course of treatment were less than the amount stated in the Schedule of Dental Plan Benefits, the unused amount does not carry forward to a subsequent course of treatment.

- s. Payment for anesthesia and intravenous (IV) sedation is allowed when provided in the dental office for covered treatment or services only when medically necessary as determined by Delta Dental and not for member convenience and is limited to a maximum of ninety (90) minutes, per episode.
- t. Orthodontic services are covered benefits subject to the following conditions and limitations:
 - (1) The obligation of the Plan ceases if the treatment plan is terminated for any reason or You are no longer eligible for benefits before completion of the case.
 - (2) Treatment may be terminated by the Dentist, by written notification to Delta Dental and to You, for lack of member interest and cooperation.
 - (3) Related services for orthodontic purposes, such as but not limited to, x-rays, extractions, space maintainers, and study models, shall be payable at the orthodontic Coinsurance percentage as specified in the Schedule of Dental Plan Benefits.
 - (4) The Plan will not pay for the repair or replacement of any orthodontic appliance.
 - (5) For orthodontic services started prior to January 1, 2006 benefits are covered **only** when provided by a Delta Dental PPO Dentist or a Delta Dental Premier Dentist.
- u. Maximum Payment:
 - (1) The maximum benefit payable in any one (1) Plan Year or any portion thereof shall be the amount indicated in the Schedule of Dental Plan Benefits as the Annual Maximum.
 - (2) Payment for orthodontic benefits shall be limited to the maximum per member specified in the Schedule of Dental Plan Benefits. Payment for orthodontic benefits shall be made on a monthly basis as determined by the number of months of treatment established by the Dentist. Payment of initial fees may be made at the time of treatment.
 - (3) The deductible amount specified in the Schedule of Dental Plan Benefits is Your responsibility. Delta Dental shall not be obligated to pay for, or otherwise discharge, in whole or in part, the first fees up to the Deductible amount.

DENTAL ACCIDENT PROVISION

For the purpose of this Benefit Description of Dental Care Coverage, claims for treatment due to an Accidental Injury to the teeth will be processed according to the terms of this Benefit Description of Dental Care Coverage except that they will not be subject to the limitations of the Annual Maximum. Delta Dental will pay for the Least Expensive Alternative Treatment. Treatment for Accidental Injury to the teeth must be received within one (1) year of the date of accident in order to be paid under this provision. Treatment received which is not the direct result of an Accidental Injury will be subject to the regular plan provisions. Coverage for treatment of the supporting structure of the teeth, including the jaw, shall **not** be covered by this Plan. The Dental Accident Provision only applies to Dental Accidents where the date of accident occurs while You are a member under this Plan.

The benefits payable for Accidental Injury of the teeth shall be limited to:

- a. Examination and diagnosis by a Dentist.
- b. Dental x-rays; restorative procedures and applicable oral surgical procedures directly related to the Dental Accident and performed as a result of the Dental Accident.
- c. Treatment and replacement, if necessary, of the teeth injured in the Dental Accident.

HOW TO USE YOUR PLAN

Make an appointment with Your Dentist. Tell the Dentist that You are covered by Delta Dental.

It is recommended that the Dentist submit a treatment plan (pre-determination) whenever extensive dental work is being considered. The Plan will determine the Allowed Amount for covered services and advise the provider. This allows You to plan for the cost of the services that will be Your responsibility to pay. Failure by your Dentist to predetermine benefits may result in a higher cost to you than anticipated if, in the professional judgment of the Delta Dental consultant, the treatment is not necessary or the Least Expensive Alternative Treatment (LEAT). Even if the Dentist does predetermine benefits, it does not obligate Delta Dental if You are no longer eligible for benefits at the time the services are actually performed or your Dentist was not a Participating Dentist with Delta Dental at the time services were performed. The treatment must commence within ninety (90) days of the date the treatment plan is submitted to Delta Dental by the treating Dentist or a new treatment plan should be obtained and resubmitted to Delta Dental.

DENTIST PAYMENT

Before treatment is started, be sure to discuss with your Dentist the total amount of the bill and the portion, if any, You will be required to pay. You are free to go to the Dentist of Your choice; however there may be a difference in the amount of payment which will be made by Delta Dental if the Dentist chosen is not a participating Delta Dental Dentist at the time services are performed.

DELTA DENTAL PPO DENTIST

Following treatment, the Dentist should forward the claim to Delta Dental. If the Dentist is a Delta Dental PPO Dentist, Delta Dental will make direct payment to the Dentist for each covered procedure. Payment will be calculated on the percentage amount identified on the PPO Panel indicated in the Schedule of Dental Plan Benefits and will be based on the Allowed Amount for services. You will receive notice of Delta Dental's payment and of the amount, if any, that you owe the Dentist.

DELTA DENTAL PREMIER DENTIST

If the Dentist is a Delta Dental Premier Dentist, Delta Dental will make direct payment to the Dentist for each covered procedure. Payment will be calculated on the percentage amount identified on the Schedule of Dental Plan Benefits and will be based on the Allowed Charge for services. You will receive notice of Delta Dental's payment and of the amount, if any, that you owe the Dentist.

NON PARTICIPATING DENTISTS

For dental benefits and services provided by a Non Participating Dentist, Delta Dental will determine the amount payable subject to the Allowed Amount and applicable Deductible and Coinsurance. This amount will be paid to You.

EMERGENCY TREATMENT

The Plan's group dental coverage includes services for emergency treatment. Each individual dental office has its own emergency treatment procedure and members should contact their Dentist and familiarize themselves with the procedure for emergencies that occur outside the Dentist's normal business hours.

TREATMENT OUTSIDE OF THE UNITED STATES

To claim dental care received outside of the United States, You must present proper documentation and records for consideration. All Plan limitations and exclusions apply. Only services that are eligible for coverage under this Plan will be considered for payment.

You will be responsible for obtaining documentation that includes but is not limited to: an itemized statement of the treatment provided that includes the member's name, date of service and a description of the services and the cost for which You are responsible. You are responsible for providing an English translation of the claim and the currency exchange rate for the date of service listed on the claim.

EXCLUSIONS AND LIMITATIONS

1. The Dental Benefits and Services Provided Shall NOT Include The Following:

- a. Coverage for any member who has been, but no longer is, an Eligible Person.
- b. Benefits or services for injuries or conditions compensable under Worker's Compensation or Employer's Liability laws; or benefits or services which are available from any Federal or State government agency, or similar entity.
- c. Benefits or services which are determined by Delta Dental to be Cosmetic Treatment including surgery; or, dentistry for Cosmetic reasons.
- d. Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges started prior to the date You became an Eligible Person.
- e. Treatment, services and appliances for banding related to orthodontics started prior to the date You became an Eligible Person.
- f. Prescription drugs, premedications and relative analgesia; hospital, healthcare facility, or laboratory charges; general anesthesia for restorative dentistry shown; preventive control programs; charges for failure to keep a scheduled visit; and charges for completion of forms.
- g. Benefits and services that are not necessary and customary as determined by the standards of generally accepted dental practice.
- h. Appliances or restorations for altering vertical dimension, for restoring occlusion, for replacing tooth structure lost by attrition or abrasion, bruxism, erosion or abfractions; for aesthetic purposes; splinting or equilibration.
- i. Benefits or services for control of harmful habits to include but not limited to tooth grinding.
- j. Treatment to correct congenital or developmental malformations.
- k. Services performed for the purpose of full mouth reconstruction.
- l. Dental care injuries or disease caused by participation in acts of violence if the member was an active participant therein including but not limited to fighting, riots or any form of civil disobedience; war or act of war; injuries sustained while in the act of committing a criminal act; injuries intentionally self-inflicted.
- m. Injuries or disease caused by atomic or thermonuclear explosion or by radiation resulting there from.
- n. Except in the treatment of accidental dental injuries, temporary services and procedures, including, but not limited to, temporary filling, sedative fillings and bases, temporary crowns and temporary prosthetic devices.
- o. Any service that is not specifically provided under the Benefit Description of Dental Care Coverage.
- p. Crowns and endodontic treatment in conjunction with an overdenture.

- q. Replacement of lost or stolen dentures or charges for duplicate dentures.
- r. Member education services.
- s. Dental benefits and services resulting from accidental injuries arising out of a motor vehicle accident to the extent such benefits and services are payable under any medical or dental expense payment provision (by whatever terminology used -- including such benefits mandated by law) of any automobile insurance policy. The excluded expenses cannot be used for any purpose under the Benefit Description of Dental Care Coverage.
- t. Any benefit, procedure or service, a motivating purpose for which is to treat, modify, correct or change an existing condition or status caused or contributed to by prior medical or dental treatment, which prior treatment was performed in accordance with then generally accepted standards of medicine or dentistry in the local community where performed.
- u. Dental benefits and services which are not completed.
- v. Services or supplies for which no charge is normally made are not covered.
- w. Cost for preparation or copying of dental claim forms, records or duplication of x-rays.
- x. X-rays taken in conjunction with non-covered services
- y. Implant/abutment for support of a removable or fixed denture; abutment supported retainer; services for repair of or removal of implants.

GENERAL INFORMATION

TIMELY FILING REQUIREMENTS

Notice of Your claim must be given to Delta Dental within ninety (90) days after you receive service. You are responsible for making sure the Dentist knows You are eligible under the program and submits the claim to Delta Dental. If a Non Participating Dentist does not submit a claim for You, You must do so yourself. If You need help submitting a claim, call or write Delta Dental.

If it is not reasonably possible for You to submit a claim within ninety (90) days after receiving services, You or someone authorized by You must submit the claim as soon as reasonably possible. No claim will be paid if not received by Delta Dental within one (1) year and ninety (90) days after You receive services.

REQUEST FOR ADDITIONAL INFORMATION

In order to process Your claim, there may be an occasion when additional information is needed. You have ninety (90) days from the date this information is requested to furnish this additional information. If the additional information is not received by Delta Dental within ninety (90) days following the request, the claim will be denied.

CLAIMS AND APPEALS

1. Purpose.

Delta Dental recognizes that from time to time members may encounter challenging situations where additional review maybe desired. When this occurs, you and your dentist are encouraged to contact Delta Dental. It is the policy of Delta Dental to promptly and fairly consider all Claims and Appeals of its members. This section outlines the procedures for and the time periods applicable to Claim decisions and Appeal decisions for Pre-determinations and Post-Service Claims. It is the policy of Delta Dental to afford members a full and fair review of claim and Appeal decisions.

2. Claims and Appeals Procedures.

- a. **Definitions.** For the purpose of this Claims Procedures Section, the following terms and their definitions apply:
- (1) **Adverse Decision** means a denial in whole or in part of a Pre-determination or a Post-Service Claim and for which you are financially responsible or, for a Pre-determination, for which you would be financially responsible, if you obtained the service.
 - (2) **Appeal** means a written request for review of an Adverse Decision that is submitted to Delta Dental by the member. All appeals must be in writing and sent to Delta Dental, P.O. Box 789769, Wichita, Kansas 67278.
 - (3) **Claim for Benefits or Claim** means a written request for benefit made by the member in accordance with Delta Dental's procedure for filing Claims. A Claim includes both Pre-determinations and Post-Service Claims. A Claim must be in writing and have sufficient information upon which to base a decision regarding benefits according to all of the provisions of the Benefit Description of Dental Care Coverage, including but not limited to the following information:
 - A. Group number and member identification number;
 - B. Member Name and Birth date;
 - C. Dentist Name and License Number;
 - D. Claim Number;
 - E. Date(s) of Service.
 - (4) **Pre-determinations** means a request for a Claims decision when prior authorization of the services is required by Delta Dental or requested by the member. Requests for advance information on Delta Dental's possible coverage of services or advance approval of covered items or services do not constitute Pre-determinations.
 - (5) **Post-Service Claim** means a request for a Claims decision for services that have been provided.
- b. **Initial Claim Decisions.** Normally, members will receive a written acknowledgement to their claims within twenty (20) days of receipt unless referred to a review committee or other unusual circumstances arise, in which case the member will be advised and an answer or decision should be received in writing within thirty (30) days of receipt.
- c. **Regional Dental Consultant.** Delta Dental is aware that the review of a claim form and x-rays may not be sufficient to come to a decision in all cases. If Delta Dental determines additional review is needed, Delta Dental may rely on the council of regional dental consultants to examine members clinically. The treating dentist is notified by Delta Dental if a member is being selected for examination by a regional dental consultant. Routine pre- and post-treatment examinations may be made to determine contractual benefits and to verify that the treatment was provided and meets the accepted standards of the profession.
- d. **Appeal of Initial Adverse Decisions (first level Appeal).** A member has the right to appeal the Initial Adverse Decision. This is a first level appeal.
- (1) The time periods that apply for Appeal decisions are as follows:

Action	Pre-Service Claim	Post-Service Claim
Time to file First Level Appeal (from the date Delta Dental made the initial Adverse Decision)	180 days	180 days
First Level Appeal Decision from Delta Dental (from the date the Appeal is received by Delta Dental)	15 days	30 days

- (2) A first level Appeal will be coordinated by a representative of Delta Dental. If the member desires an additional review of the Claim, a second level Appeal can be requested.

e. **Appeal of Adverse Decisions from a first level appeal (second level Appeal).**

A member has the right to appeal an Adverse Decision from a first level appeal. This is a second level appeal.

- (1) The time periods that apply to second level appeal decisions are as follows:

Action	Pre-Service Claim	Post-Service Claim
Time to file Second Level Appeal (from the date Delta Dental made the Adverse Decision on the first level appeal)	90 days	90 days
Second Level Appeal Decision (from the date the Appeal is received by the Group)	15 days	30 days

- (2) A second level Appeal will be coordinated and the determination made by Benefits Staff of the Kansas Health Policy Authority. The second level is the final level of the Appeal process.

PLAN LIABILITY

Delta Dental shall have no liability for any conduct of any third party, including but not limited to tortuous conduct, negligence, wrongful acts or omission, or any other act, of any person, including but not limited to employees, dentists, dental assistants, dental hygienists, hospitals or hospital employees receiving or providing services, and shall also have no liability for any services or facilities which, for any reason, are unavailable to You.

RIGHT TO INFORMATION

As a condition precedent to the approval of claims hereunder, Delta Dental, upon its request, shall be entitled to receive from any attending or examining Dentist, or from hospitals in which a Dentist's care is rendered, such information and records relating to Your attendance to, or examination, or treatment rendered to You as is needed in the administration of such claims. Delta Dental, at its own expense, shall have the right and opportunity to require You to be examined when and as often as it reasonably requires during the pending of a claim under this Benefit Description of Dental Care Coverage and the right and opportunity to make an autopsy if it is not prohibited by law. The accepting by You of any benefit of coverage under this Benefit Description of Dental Care Coverage constitutes the automatic and irrevocable consent by You and the Provider of service for the release to Delta Dental of any and all of the information and records before described, and a full waiver by You that any of such information and records that otherwise is privileged.

CONFIDENTIALITY

Delta Dental agrees that it has individual health information and other proprietary information (collectively, "Information") which is valuable, special, private, and unique. Delta Dental will not divulge, disclose or communicate in any manner any information to any third party without prior written consent of the member. Delta Dental will protect the Information and treat it as strictly confidential.

MISREPRESENTATIONS

No statements made by the Group or by an individual employee shall be deemed warranties, and no statement by the Group or employee shall be used in defense of a claim or in any other dispute under the Benefit Description of Dental Care Coverage, unless it is contained in a written instrument, a copy of which has been furnished to, the Group, employee or personal representative thereof and, if such statement was made in the application of this Benefit Description of Dental Care Coverage, which application or an exact copy thereof is included in or attached to this document.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Benefit Description of Dental Care Coverage prior to the expiration of sixty (60) days after final notice of claims has been filed in accordance with the requirements of the Benefit Description of Dental Care Coverage nor shall any action be brought after five (5) years from the date the claim for benefits was presented to the Plan.

GOVERNING LAW

The entire Benefit Description of Dental Care Coverage document shall be interpreted and enforced according to applicable laws of the State of Kansas and the Public Health Service Act, except to the extent such laws are preempted by the Employee Retirement Income Security Act of 1974 (ERISA).

ELIGIBILITY OF MEMBERS AND THEIR DEPENDENTS

- a. Eligibility is determined by the Group.
- b. At termination of coverage under this Plan, operative procedures then in progress which are completed within thirty (30) days of the termination of coverage and submitted for payment within six (6) months of such termination shall be covered. For this purpose, operative procedures are defined as and limited to root canal therapy on permanent teeth; individual crowns; dentures, partial and complete; and bridges and are considered in progress only if all procedures for commencement of lab work have been completed.

COORDINATION OF BENEFITS (COB)

- a. For purposes of this section, "This Plan" means that portion of the Benefit Description of Dental Care Coverage that provides the benefits that are subject to this provision. "This Plan" will not duplicate benefits for dental care service for which You are entitled under any of the following plans:
 - (1) Group, blanket, or franchise insurance.
 - (2) Group practice, individual practice, and other prepayment of coverage on a group basis. (This includes group contracts issued by the Plan).
 - (3) Labor-management trusted plans.
 - (4) Union Welfare plans.
 - (5) Employee benefit organization programs.
 - (6) Coverage under government programs.
- b. Order of Benefit Determination Rules
When two (2) or more plans pay benefits, the rules for determining the order of payment are as follows:
 - (1) The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
 - (2) A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary.
 - (3) A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
 - (4) The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
 - A. Non Dependent or Dependent – The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare Beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. retiree employee); then the order of benefits between the two (2) plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
 - B. Child Covered Under More Than One (1) Plan – The order of benefits when a child is covered by more than One (1) Plan is:
 1. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - The parents are married:

- The parents are not separated (whether or not they ever have been married); or
 - A court decree awards joint custody without specifying that one (1) party has the responsibility to provide health care coverage.
2. If the specific terms of a court decree state that one (1) of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination period or plan years commencing after the plan is given notice of the court decree.
 3. If the parents, are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;
 - The plan of the non custodial parent; and then
 - The plan of the spouse of the non custodial parent.
- C. Active or Inactive Employee – The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule b (1).
 - D. Continuation Coverage – If a person whose coverage is provided under a right of continuation provided for by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as the person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - E. Longer or Shorter Length of Coverage – The plan that covered the person as an employee, member, subscriber or retiree longer is primary.
 - F. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been primary.
- c. Effect On The Benefits Of This Plan

When this Plan is secondary, it may reduce its benefits so that the total benefit paid or provided by all plans are not more than 100% of the total allowable expenses.
 - d. Right To Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Delta Dental may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person's claim benefits. Delta Dental need not tell, or get the consent of any person to do this. Each person's claim benefits under this Plan must give Delta Dental any facts it needs to apply those rules and determine benefits payable.
 - e. Facility Of Payment

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, Delta Dental may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. Delta Dental will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.
 - f. Right Of Recovery

If the amount of the payments made by Delta Dental are more than it should have paid under this COB provision, it may recover the excess from one (1) or more of the persons it has paid or for whom it has paid; or another person or organization that may be responsible for the benefits or services provided for the covered person. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

FRAUDULENT, GROSS MISBEHAVIOR OR MISREPRESENTATION

Your coverage and/or Your dependent(s) coverage may terminate, on the date specified by the Group, if You and/or Your dependent intentionally carries out any act that constitutes fraud, gross misbehavior, misrepresentation, omission of facts or any other criminal act in applying for or seeking benefits under the Plan as determined by the Group, which includes but is not limited to:

- a. A member and/or dependent who misrepresents or omits material facts to include the unauthorized use of a dental plan identification card to obtain supplies or services, which are not prescribed or ordered for the member and/or dependent or which the member and/or dependent is otherwise not entitled to receive. In this instance, Coverage for the member and/or dependent(s) may be terminated by the Group.
- b. A member and/or dependent who permits the unauthorized use of a dental plan identification card for any person not covered under the Plan to obtain supplies or services in which they were not otherwise entitled to receive. In this instance, Coverage of the member and/or dependent(s) may be terminated by the Group.
- c. If the member and/or dependent steals and/or uses another person's Group dental plan identification card to obtain supplies or services in which they were not otherwise entitled to receive, the member and/or dependent(s) may be terminated by the Group.
- d. Any other improper action as determined by the Group.